FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments During the annual licensure survey conducted on October 18 - 24, 2011 the facility was cited a Type "A" penalty for failure to be administered in a manner to ensure an effective system was in place to ensure injuries of unknown origin were thoroughly investigated, resulting in an injury of unknown origin not being thoroughly investigated or reported to the state for one (#12) resident, failed to ensure the supervision and safe use of a wheelchair for one (#15) resident from harming self and others, and failed to ensure social services were provided for residents (#12, #15, #27, #30) with behaviors for forty-nine residents reviewed which placed resident #12, #15, #27, & #30 in an environment which was detrimental to health, safety and welfare. Complaint investigation #27684, #27758, and #27833, were completed during the annual licensure survey. No deficiencies were cited related to the complaint investigations under N401 Chapter 1200-8-6, Standards for Nursing Homes. 11/08/1 A. Resident #12-Discovered bruise on N 401 N 401 1200-8-6-.04(1) Administration July 22, 2011. Clinical manager reviewed accounts July 25, 2011 (1) The nursing home shall have a full-time given by nurse and CNA on duty (working at least 32 hours per week) during initial discover. ADON administrator licensed in Tennessee, who shall reviewed account on July 25, 2011. not function as the director of nursing. Any Reopened investigation 10/28/11. change of administrators shall be reported in writing to the department within fifteen (15) days. ADON re-interviewed nurses and The administrator shall designate in writing an CNA's on duty during initial individual to act in his/her absence in order to discovery. Investigation was

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provide the nursing home with administrative

direction at all times. The administrator shall

resources and personnel required to meet the

assure the provision of appropriate fiscal

needs of the residents.

**PBF211** 

completed 11/1/11. No other action

was required. No intentional injury

occurred based on resident behavior

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N 401	facility policy review, failed to be administe an effective system winjuries of unknown o investigated, resulting origin not being thoro (#12) resident, failed and safe use of a who resident from harming to ensure social serviresidents (#12, #15, #forty-nine residents reresident #12, #15, #2 that was detrimental twelfare.  The findings included During interview with October 21, 2011, at room, revealed the form the Administrator agorigin, including injury would require a thoro Medical Director, nurselective and the form the Administrator states and the form the Administrator and upon (specific to the LCSW 2011, when the	as evidenced by:  a, medical record review and interview, the facility red in a manner to ensured in a manner to ensure the record review and injury of unknown and injury of un	ty ure tre tre tre tre tre tre tre tre tre t	N 401	and reaction to others was uno further incident of this ty recurred. Abuse coordinator reviewed all documentation 11/1/11 of investigation and was substantiated per clinical assessment. The medical diseasessment. The medical disease was notified by DON on Occ 2011. NP was notified by DOC Cober 28, 2011. Medical was NP were notified of investompletion on 11/8/11 by Document of the provided of investompletion on 11/8/11 by Document of the provided on a provided in the provided on November 6, 2011 was considered on the provided of the provided on the provided of the provided on the provided on the provided of the provided on the prov	rector ctober 25, DON on director stigation DON. No State 11.  In our work.  In our wo			

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN0601 10/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 401 Continued From page 2 N 401 serviced nursing staff on plan and stated, "...maybe she isn't the Coordinator, .. I'm placed plan in chart on 10/28/11 and not sure it is in writing...maybe that is a weak also copy of plan placed in Behavior area." Sheets book at nurses station. The Administrator verified the nursing staff Resident #15 has had a behavior members involved in assessing the injury of component added to his care plan unknown origin for resident #12 did not have the 10/27/11 by social services assistant education and training necessary to determine if assigned to that resident. After social assult could be ruled out. During the interview, service director (LCSW) assessed the Administrator stated, "I'm not the guy to tell resident, on 10/27/11an you we were 100%..." individualized written behavior management plan was formulated and The Administrator verified there were no then social service director inquestions or discussions related to the injury of serviced nursing staff on plan and unknown origin for resident #12 with the placed plan in chart on 10/28/11. Administrator prior to October 20, 2011, One on one was already in place and "Yesterday (October 20, 2011) I talked to the continued until out to hospital for wound care nurses...people did check her ...documentation is not 100%..." unrelated medical issues on 11/3/11. Resident #27 has had a behavior The Administrator confirmed the Medical Director component added to his care plan was not informed of the injury of unknown origin 10/28/11 by social services assistant for resident #12. assigned to that resident. After social service director (LCSW) assessed When the Administrator was asked about resident, an individualized written resident #15's unsafe behaviors with wheelchair behavior management plan was and whether aware resident #27 had an formulated and then social service altercation with resident #15 and resident #30 had director in-serviced nursing staff on hit resident #12 in the face, the Administrator plan and placed plan in chart on responded, "I can't possibly know about all the 10/28/11. behaviors...I knew about 2 or 3...I wasn't aware of Resident #30 has had a behavior what (resident #15) was doing with...wheelchair." component added to his care plan Continued interview confirmed the facility did not have a behavior management program and 10/28/11 by social services assistant stated, "we are working on it right now..." assigned to that resident. After social N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN0601 10/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 401 Continued From page 2 N 401 stated, "...maybe she isn't the Coordinator, .. I'm service director (LCSW) assessed resident, an individualized written not sure it is in writing...maybe that is a weak area." behavior management plan was formulated and then social service The Administrator verified the nursing staff director in-serviced nursing staff on members involved in assessing the injury of plan and placed plan in chart on unknown origin for resident #12 did not have the 10/28/11. In-servicing on behavior education and training necessary to determine if management policy, abuse policy, & assult could be ruled out. During the interview, incidents of unknown origin began on the Administrator stated, "I'm not the guy to tell 10/28/11 and all staff were inyou we were 100%..." serviced by 11/7/11 unless on vacation or leave and they will be in-The Administrator verified there were no serviced on date of return to work. questions or discussions related to the injury of All agency staff will be in-serviced unknown origin for resident #12 with the prior to work. Administrator prior to October 20, 2011, B. All residents with incidents of "Yesterday (October 20, 2011) I talked to the wound care nurses...people did check her unknown origin have the potential to ...documentation is not 100%..." be affected by this deficient process. Incident reports from July 22, 2011 to The Administrator confirmed the Medical Director current were reviewed by ADON on was not informed of the injury of unknown origin 11/7/11 and review of 44 unknown for resident #12. incidents required no further action. Incidents of unknown origin are When the Administrator was asked about being reviewed by nursing resident #15's unsafe behaviors with wheelchair management initially (daily as and whether aware resident #27 had an occurrence) and ADON (OA nurse) altercation with resident #15 and resident #30 had receives incident, and the hit resident #12 in the face, the Administrator investigation begins immediately, the responded, "I can't possibly know about all the abuse coordinator and administrator behaviors...I knew about 2 or 3...I wasn't aware of immediately receive copy of incident what (resident #15) was doing with...wheelchair." Continued interview confirmed the facility did not as notification to begin investigation. have a behavior management program and MD/NP will be notified of each stated, "we are working on it right now..." incident as well as contact person N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from

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(15) Each nursing home shall adopt safety policies for the protection of residents from N 424

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMB		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE		
N 401	not sure it is in writing area."  The Administrator ver members involved in a unknown origin for reseducation and training assult could be ruled at the Administrator state you we were 100%"  The Administrator ver questions or discussion unknown origin for research and care nursespdocumentation is not informed of the Administrator cor was not informed of the for resident #15's unsafe and whether aware realtercation with resident #12 in the responded, "I can't pobehaviorsI knew abwhat (resident #15) w Continued interview of	isn't the Coordinator,maybe that is a weal iffied the nursing staff assessing the injury of sident #12 did not have genecessary to determine out. During the intervieed, "I'm not the guy to the injury sident #12 with the October 20, 2011, 20, 2011) I talked to the october 20, 2011, and injury of unknown or injury of	the ne if ew, ell of air O had reare of nair."	N 401	D. Incidents will be reviewed at discussed in the weekly meenursing admin., rehab depart rep., pharmacy consultant, in director, administrator, and a appropriate staff according to of incident.  Administrator will read and all reports concerning potent abuse/injuries of unknown of along with the incident report also interview personnel have direct knowledge of the incident does not and this information will be in the QA meeting for review follow up.	ting with ment ledical lany other lo nature  review ial rigin rt and ing any dent to reoccur included		
N 424	1200-8-604(15) Adn (15) Each nursing hor	<u> </u>		N 424				
	policies for the protec	tion of residents from			· ·			

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September 25, 2011 - two facility documentation,

one for "ran w/c into another resident's knees and ran w/c into another resident's w/c" and a second dated and timed the same as the first report "ran

meeting. In-servicing began on

10/28/11 and all staff were in-

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CLEVELAND, TN 37312  (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST as PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 424  Continued From page 5  over another resident's feet" September 26, 2011 - facility documentation for a skin tear to the left forearm found when long-sleeve shirt removed to shower September 30, 2011 - an ew bruise to the right upper extremity (Weekly Skin Report)  October 2, 2011 - facility documentation, "rolled w/c into something and got a skin tear to fight hand" October 4, 2011 - skin lear of the right dorsal hand documented in Nurse's Notes October 7, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) and (the other resident) and the other resident of provident reviews of the resident's contant motion with whe with small bruises (Weekly Skin Report)  Review of the resident's polentially related to NonambulatoryInterventionsprimary mode of locomotion is the whe	NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	Y, STATE, ZIP CODE			
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  N 424  Continued From page 5  over another resident's feet" September 26, 2011 - facility documentation for a skin tear to the left forearm found when long-sleeve shirt removed to shower September 26, 2011 - facility documentation, "rolled wic into something on Wing 4 and ran into something and got a skin tear to right hand" October 2, 2011 - facility documentation, "rolled wic into something on Wing 4 and ran into something and got a skin tear to right hand" October 7, 2011 - facility documentation for skin tear of left hand/third finger October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 14, 2011 - two skin tears right dorsal hand and bilateral upper extremities with small bruises (Weekly Skin Report)  Review of the resident's Plan of Care (POC) revealed, "7720/2011 - ADL (activities of daily living) Functional Deficit, potentially related to Nonambulatory. Interventionprimary mode of locomotion is the wheelchair (w/c)" Further review of the POC revealed the Problem 'Activities' dated July 18, 2011, and did not include any interventions specific to the resident's constant motion with the w/c and moving throughout three of four wings of the facility.	BRADLEY	HEALTH CARE & REHA	В			12			
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POC included had a Target Date for the Goals moved forward to January 2012, but the Problems did not include the behavior displayed that had contributed to the resident being injured repeatedly with skin tears and negative interactions with fellow residents.  Review of the August 31, 2011, Nurse's Notes revealed a 5:00 p.m., "Spoke with wife and required given. In-services of updates to direct care staff by nursing management was completed 11/8/11. Residents with restraints were observed on 10/19/11 by nursing management & rehab staff regarding appropriate placement and no other restraints were placed incorrectly.	N 424	over another resident September 26, 2011 - skin tear to the left for long-sleeve shirt remo September 30, 2011 - upper extremity (Wee October 2, 2011 - faci w/c into something or something and got a something and got a something and got a something and documented in loctober 4, 2011 - faci tear of left hand/third October 9, 2011 - faci "bumped into (another resident) got angry ar October 14, 2011 - two hand and bilateral upportions (Weekly Skin Review of the resident Poc review of the Poc review revealed all the Poc included had a moved forward to Jar Problems did not include that had contributed to repeatedly with skin to interactions with fellow Review of the August	Is feet" - facility documentation rearm found when oved to shower - a new bruise to the rig kly Skin Report) - facility documentation, "roll with a different to right hand" - tear of the right dorsa Nurse's Notes - fility documentation for stillity documentation, resident) and (the other documentation, resident) and (the other documentation) - resident and (the other documentation) - ADL (activities with small related to the resident (w/c)" - ADL (activities of daily cit, potentially related to the resident on the wealed the Problem - 18, 2011, and did not consider to the resident with a did not consider the word of the facility Target Date for the Goaluary 2012, but the under the behavior display to the resident being injears and negative we residents.  - 31, 2011, Nurse's Notes - 18   19   19   19   19   19   19   19	for a ght lled l skin er " all all y o e of er dent's the als uyed ured	N 424	vacation or leave and they we serviced on date of return to All agency staff will be insprior to work.  B. All residents have the potent adversely affected by this deprocess. Residents at risk at identified by incident report screens, admission history, a residents with restraints. Rewith behavioral problems not supervision to prevent self the negative interaction were ided by MDS assessment, behavioral service staff begin 11/4/11 & completed 11/7/11 have been reviewed and uponeded and in-servicing of a completed 11/7/11 by SS stanursing management. Residentified by nursing management per review of assessment on 11/7/11 – 19 CP's were updated by nursing management to reflect care required/given. In-services updates to direct care staff to management was completed Residents with restraints we observed on 10/19/11 by nu management & rehab staff rappropriate placement and response.	vill be in- work. erviced  tial to be efficient re s, rehab and esidents eeding harm and entified for sheets, terviews ning 1. CP's lated as updated aff & lents ensiers  CP and resident ing  of oy nursing 1.1/8/11. ere rrsing regarding no other		

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN0601 10/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 Continued From page 6 N 424 Daily observation by nurses & made aware of new skin tear. Wife has concern nursing management during care for WC (wheelchair) safety..." continues and in-servicing by nursing management & rehab will continue Observation in the Wing I dining room from 5:45 on orientation and per occurrence. a.m., until 6:30 a.m., on October 18, 2011, Residents with alarms were checked revealed resident #15 seated in a high back w/c for activation by nursing management without foot pedals or leg rest, using feet to on 10/18/11 with no other alarms not propel around the large dining. Observation activated. Review of alarms were revealed seventeen residents in the dining room done on 11/7/11 by nursing at 5:45 a.m., with ten of the seventeen residents management with no further action asleep in their chairs. needed. CNA round sheets include Observation of resident #15 from 5:45 a.m., until checking of alarms. All other 6 6:30 a.m., on October 18, 2011, with the resident biohazard doors were checked by propelling forward and backwards at intervals, revealed the following: Bumped into a sleeping environmental service director and resident (#20) with the back of the w/c and keys moved & signs placed where no resident #20 jerked their hand away from the arm key pad is in place. Residents at risk of their w/c resident #15 had come into contact are reviewed in weekly sub QA with and resident #20 yelled, "Get away!"; meeting with nursing management, propelled w/c into the wheelchairs of residents rehab, SS staff, medical director, (#25 & #30); proceeded to move from the back of pharmacy consultant. Supervision to: the room to the front of the room, circling to the prevent behavior issues resulting in left past two tables with residents seated in their harm to self & others, prevent wheelchairs; then, while in a forward motion, inappropriate transfers resulting in bumped into the oxygen tank of resident #26; and harm, using transfer bumped into the back of the w/c of resident #12 recommendations appropriate for (asleep in w/c). Observation revealed there were residents, applying ordered no staff members in the dining room for the forty-five minutes when resident #15 was roaming appropriate restraint properly, the dining room in constant movement. securing biohazard rooms, and appropriate alarms in working order Observation and interview at 6:30 a.m., on & activated, will be provided by October 18, 2011, with the Licensed Practical nurses, nursing staff, nursing Nurse (LPN #10) who entered the dining room management, psych NP, therapy upon request and observed the constant dept., social services, activities, movement, bumping w/c into other residents, administrator, MD/NP, medical revealed. "He doesn't need to be in here...the director by in-servicing at monthly Clinical Manager (CM) recently put (resident #15)

on the Get Up List "

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 424 N 424 Continued From page 7 mandatory meetings as needed by Observation of Wing I Dining Room on October occurrence. Nursing management 18, 2011, from 11:55 a.m., until 12:35 p.m., will do compliance rounds/ daily revealed resident #15 seated with the back of observation and will make referrals to w/c against the dining room wall to the left of the therapy, social service dept. and double door. Observation included approximately psych NP as needed. Review of forty-five residents seated at ten tables eating residents identified at risk will be with five staff members and three family done weekly with this team & members in the room assisting residents. medical director as resident need dictates. Observation at 12:20 p.m., revealed resident #15 C. Each incident of unknown origin & propelled the w/c (using the feet) forward behavior issues will be reviewed approximately eight feet and rammed the w/c into daily upon occurrence. Also the dining table where resident #14 was seated. incidents of unknown origin, Observation continued and the ramming motion was repeated three more times, then resident behavior issues, restraint #15 retreated about four feet, paused for four application/elimination and alarm minutes, and then rammed into the same dining application/elimination will be table again. Observation revealed certified reviewed weekly at sub QA meetings. nursing assistant (CNA #12) came to the table of The administrator attends all weekly resident #14 and took resident #15 back against sub OA meetings unless outside the dining room wall. Continued observation facility and receives reports as revealed the third food cart arrived at 12:30 p.m., appropriate. Education & training of and CNA #12 began to feed the resident. staff regarding abuse, unknown origin incidents, Behavior Management Interview at 8:00 a.m., on October 19, 2011, with Plans will be ongoing. Administrator the Director of Nurses (DON) and the Wing I will continue to be involved in in-Clinical Manager, at the Wing I nursing station, services. revealed the following: The "Get Up List" was developed by the CM and listed twenty-one D. Administrator will read and review residents to be gotten up prior to 7:00 a.m. and all reports concerning potential included eleven residents designated, " ... to be abuse/injuries of unknown origin gotten up EVERY DAY!!!"; the List contained along with the incident report and seven residents with behaviors; the CM was also interview personnel having any aware resident #15 was frequently in the dining direct knowledge of the incident to room in the early morning hours unsupervised; ensure that incident does not reoccur and confirmed the first of three food tray carts and this information will be included were not delivered to the Wing I dining room in the QA meeting for review and before 8:15 a.m. Interview continued related to follow up. the observed "ramming of the dining table at

lunch the prior day and the CM stated resident

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N 424	Continued From page 9			N 424				
	Interview verified resident #15 had no behavior management program to address the unsafe behavior. Interview revealed the facility did not have a written behavior management policy or program.							
	Interview on October 21, 2011 at 9:10 a.m., with the Nurse Practitioner (Psych Mental Health Nurse Practitioner/PMHNP) contracted for psychiatric consults on October 21, 2011, at 9:10 a.m., in the Director of Nurse's office revealed the social services staff had not formally requested a consult related to the resident and stated the primary responsibility for addressing behaviors was with the facility's Licensed Clincal Social Worker (LCSW). Interview confirmed the PMHNP had not followed up to see if the evening behaviors were being documented as was requested on October 10, 2011.		9:10 ed the ted a e ors I	9				
2** *- •	20, 2011, at the Wing the nursing staff were	ed on October 10, 2011	rmed					
	2011 revealed under resident (#22) stated, all the time" Review Grievance Form initia #22's complaint revea Wing I Clinical Manage concern d/t (due to) of dementia bumping in res and keep (resid Instructed this res to other res coming town	one particular Res (#15 toasks staff to watch ent #22) away from thi call staff whenobserv	d into I dent ne ) with other s res.	4				

PRINTED: 11/01/2011 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG\_ TN0601 10/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 10 residents, on October 25, 2011, in the Wing II dining room, the resident council interim president (resident #27) stated resident #15 continued to be a issue for the residents due to bumping fellow residents with...w/c. During the Group interview, resident #22 stated, "...my sister had to get (resident #15) off (another unnamed resident)...mashing with w/c." Continued interview revealed several residents in the group interview referred to resident #15 as, 'the rammer." Interview on October 20, 2011, at 4:00 p.m., with resident #19, in the resident's room, revealed, "(Resident #15) goes so fast (resident #15) could hurt someone." Continued interview with resident #19 revealed resident #15 was "dangerous" and the resident was afraid of resident #15. Continued interview revealed the resident used a walker for ambulation and couldn't get out of resident #15's way if was too close. Interview on October 20, 2011, at 9:30 a.m., with resident #22 in the resident's room revealed, "...a couple of weeks ago" resident #15 had bumped into resident #22's walker causing the walker to hit their legs, while seated in the dining room. Review of the facility's documentation confirmed the incident had occured on September 25, 2011, and the resident had sustained no injury. Interview on October 20, 2011, at 3:30 p.m., with resident #27, in the resident's room, revealed

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resident #15 was named the Wild Man by resident #27. Interview continued and resident #27 stated, "The Wild Man backs into people, rams people, and hits the glass wall in the dining room...tired of (resident #15) coming into my room and them not doing anything about it...I doused him with my water pitcher and he

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN0601 10/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) N 424 Continued From page 11 N 424 shivered..." Interview on October 20, 2011, at 4:30 p.m., with residents' #36, #37, and #38, in the dining room. confirmed resident #15 "was confused and was always rolling the wheelchair in the dining room bumping into residents." Interview further revealed they, "knew to watch for him and keep out of his way." Interview on October 20, 2011, at 4:25 p.m., with resident #40, in the resident's room, revealed resident #15 had bumped into resident #40's wheelchair from behind last week while seated at a dining room table. Continued interview revealed resident #40 had been pushed into the edge of the table, but was not injured. Continued interview revealed resident #40 was afraid of 5 resident #15 and "watched out" to see the whereabouts of resident #15. During an extended interview with the Administrator on October 21, 2011, at 9:10 a.m., in the conference room, related to injuries of unknown origin and resident behaviors, the administrator verified signing six of the reports filed for resident #15 and stated, "I can't possibly know about all the behaviors...I knew about 2 or 3...I wasn't aware of what (resident #15) was doing with...wheelchair." During the interview, the administator verified the facility did not have a behavior management program and stated, We are working on it right now..." Resident #8 was transferred to the facility from a Hospice in another state on July 20, 2010, with diagnoses including Advanced Dementia with Psychotic Features, history of Right Shoulder

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Repair, Osteoarthritis, and Kyphosis.

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Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 424 N 424 Continued From page 13 as the care plan provided for the certified nursing aides (CNA) prior to June 1, 2011, revealed under the heading 'Assistance-Transfer' the boxes for two (persons) and Wt. (weight) Bearing were checked with "limited" penciled in next to Wt. Bearing. Review of the facility's Investigation/Witness Accounts Form (written statement) of one of the two CNAs (certified nursing assistant #1) performing the transfer at the time resident #8 was injured revealed, "Another CNA asked me to come into the room to assist with transferring a resident into the shower chair. As we were transferring resident into the chair we had to place resident on the floor due to slipping. Resident set with one leg under bottom and one out in front with her back resting on my legs. We called for assistance and while waiting for assistance we got resident's leg out from under her. Resident complained of pain once back in bed after shower. I advised other CNA to inform nurse to make sure resident was okay." Review of the second CNA's statement (CNA #2) revealed the resident was placed into the shower chair after a third CNA arrived to help and was put back into the bed after the shower was completed with a weight-bearing transfer performed by CNAs #1 and #2. Review of the Investigation/Witness Accounts Form completed by the CNA (#11) assisting the resident the following morning, June 2, 2011, revealed, "...This morning at breakfast when I pulled...up...complaining terribly in pain with...leg...pulled the cover up and noticed...knee very swollen...ankle area bruised...went and got...nurse on duty."

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N 424	Medical record review September 23, 2011, total dependence for decision making, and occurred four to six d. Medical record review Program Interventions updated March 12, 20 person transfer with remaining the Medical record review of Care dated Septem "At risk for Falls R/I physical mobility, neumodication useassi level of: Total with medical with with medical with medical with with medical with medical with medical with with with with with with with with	v of an assessment date revealed the resident variansfers, independent other behavioral sympays a week.  v of the Falls Preventions dated March 1, 2010, 2011, revealed "one to mechanical lift"  v of the Interdisciplinary of the Interdiscipl	was for toms  n and two  y Plan d	N 424				
	Observation on Octol the resident's room, r #10 transferred the re to the bed with a gait Interview with Registo October 20, 2011, at Nurses' Station, confi transferred with the n failed to provide a sa Resident #5 was adm	per 20, 2011, at 8:18 a. evealed CNA #9 and Cesident from the wheeld belt.  ered Nurse (RN) #4 on 9:05 a.m., in the Wing irmed the resident was nechanical lift and the fet ransfer.  mitted to the facility on Appear including Dementiale Weakness and	CNA chair Two to be facility					
=	Medical record review August 29, 2011, review and long term memo	w of an assessment da realed the resident had ry problems, required l person physical assist f	short imited					

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG TN0601 10/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 424 Continued From page 17 N 424 transfers, dressing, and bathing. Medical record review of the Interdisciplinary Plan of Care dated July 26, 2011, revealed "...Restraint Use: Soft Belt, potentially related to Unsteady gait...Risk Factors...falls, injury..." Medical record review of the Physician's Orders dated October 1, 2011, revealed, "...soft belt restraint while up in wheelchair D/T (due to) unsteady gait and cognitive impairment..." Review of the manufacturer's application instruction sheet for the lap belt revealed, "...lay the belt across the patient's lap...bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard...go around the back post and cross the straps behind the patient...secure the loops on the wheelchair tilt levers...belt should be over the patient's hips at a 45-degree angle holding the hips against the back of the chair..." Further review revealed "...adverse reactions: The patient may become restless or agitated if the device is uncomfortable...severe emotional, psychological problems may occur if a patient's movement is severely limited..." Observation and interview on October 18, 2011, at 6:45 a.m., in the Wing IV dining room, with Licensed Practical Nurse (LPN) #4 revealed the resident seated in a wheelchair with a soft belt yelling loudly. Continued observation and interview revealed the right strap of the belt was between the wheelchair seat and the wheelchair

instructions.

skirt and the left strap of the belt was placed over the wheelchair skirt. Continued interview confirmed the soft belt restraint was not applied correctly according to the manufacturer's

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	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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N 424	Continued From page 18			N 424				
	Medical record review of the Interdisciplinary Plan of Care dated July 26, 2011, revealed, "assist in transferlimited assist of one person"							
	Medical record review of the Physical Restraint Elimination Assessment dated August 7, 2011, revealed, "non-ambulatory chairboundpartial weight bearing/assist of one for transfer"						-	
	Observation on October 18, 2011, at 9:50 a.m., in the resident's room, revealed Certified Nurse Aide (CNA) #6 and CNA #7 transferred the resident from the wheelchair to the toilet, by lifting the resident under the arms.			R				
	Interview with CNA #6 on October 18, 2011, at 10:00 a.m., in the resident's bathroom, confirmed a gait belt was to be used when transferring residents and the CNA's had failed to use a gait belt.							
	Interview with Occupational Therapist Registered (OTR) #1 on October 18, 2011, at 12:10 p.m., in the Wing Two Nurses' Station, confirmed a gait belt was required for all transfers but there was no written policy. Continued interview confirmed all staff were educated upon hire and periodically during employment to "always" use a gait belt during transfers. Continued interview revealed it was not appropriate to lift a resident under the arms due to the potential for injury such as shoulder/arm fracture and the facility failed to provide a safe transfer.							
		mitted to the facility on with diagnoses includi ident, Motor Vehicle	ng				100	

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PRINTED: 11/01/2011 FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING TN0601 10/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) director in-serviced nursing staff on N 780 | Continued From page 21 N 780 plan and placed plan in chart on resident, resulting in resident #12 being "slapped 10/28/11. across the face...seperated residents." Resident #30 has had a behavior component added to his care plan Review of a facility investigation dated January 10/28/11 by social services assistant 17, 2011, revealed another resident, "slapped assigned to that resident. After social (resident #12) scratching the nose, a small service director (LCSW) assessed amount of bleeding occurred...seperated resident, an individualized written residents...assessed for injuries." behavior management plan was formulated and then social service Review of a facility investigation dated March 28, director in-serviced nursing staff on 2011, revealed "resident became agitated and plan and placed plan in chart on began clawing at CNA (Certified Nursing 10/28/11. In-servicing on behavior Assistant)." management policy, abuse policy, & incidents of unknown origin began on Review of a facility investigation dated May 16, 2011, revealed an altercation, witnessed by 10/28/11 and all staff were in-Activity Department staff, in Wing One dining serviced by 11/7/11 unless on room, resulted in resident #12 being sent to the vacation or leave and they will be in-ER (Emergency Room) due to multiple scratches serviced on date of return to work. on the face and a cut to the left eye. All agency staff will be in-serviced prior to work. Review of a facility investigation dated August 23, B. Residents who exhibit intrusive, 2011, revealed, "resident was propelling self in aggressive, reactive tendencies will wheelchair...when another resident began hitting be assessed by social service resident (#12) in the face with fists...hematoma department by 11/7/11 and care (bruise) above left eye...seperated residents." planned after assessment on 11/7/11. In-servicing of updated interventions Review of a facility investigation dated October to direct care staff by social service 15, 2011, revealed, "...(resident #12) grabbed res staff was completed on 11/8/11. Staff (resident #30) by the arm and would not release...then res (#30) started hitting res (#12) on vacation or leave will be inon the R (right) lower jaw." serviced on date of return to work. All agency staff will be in-serviced Interview with the Wing One Clinical Manager prior to work. Also, any resident (CM) confirmed resident #12 had frequently upon admission who has a history of exhibited behaviors resulting in resident to similar behaviors will be assessed by

resident altercations. Interview continued and the

CM verified the social services staff were

responsible to assess behaviors and address behaviors and confirmed behaviors were not

social service director and/or

assistants as part of the social history

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING B. WNG\_ TN0601 10/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 780 Continued From page 23 N 780 be daily regarding prevention & 'Other behavioral symptoms not directed toward intervention. others' occurred 4 to 6 days a week. Each incident of unknown origin & behavior issues will be reviewed Review of the resident's Plan of Care (POC) daily upon occurrence. Also revealed the problems did not include the incidents of unknown origin, behavior displayed contributing to the resident behavior issues, restraint being injured repeatedly with skin tears and application/elimination and alarm negative interactions with fellow residents. application/elimination will be Review of the August 31, 2011, Nurse's Notes reviewed weekly at sub QA meetings. The administrator attends all weekly revealed a 5:00 p.m., entry, "...Spoke with wife and made aware of new skin tear. Wife has sub OA meetings unless outside concern for WC (wheelchair) safety..." facility and receives reports as appropriate. Education & training of Observation in the Wing I dining room from 5:45 staff regarding abuse, unknown origin a.m., until 6:30 a.m., on October 18, 2011, incidents, Behavior Management revealed the resident in a high back wheelchair Plans will be ongoing. Administrator (w/c) without foot pedals or leg rest using feet to will continue to be involved in inpeddle around the large dining. Observation services. revealed seventeen residents in the dining room D. Administrator will read and review at 5:45 a.m., with ten of the seventeen residents all reports concerning potential sleeping. abuse/injuries of unknown origin Observation included the resident being in along with the incident report and forward and backwards motion at different times, also interview personnel having any was first observed in front of the floor to ceiling windows at the back part of the room, and then direct knowledge of the incident to came into contact with six other residents' ensure that incident does not reoccur wheelchairs as follows: Bumped into a sleeping and this information will be included resident (#20) with the back of w/c and they in the QA meeting for review and jerked their hand away from the arm of their w/c follow up. that resident #15 had come into contact with and yelled, "Get away!"; then glanced off of the wheelchairs of two male residents (#25 & #30; proceeded to move to the right and to the front of the room, circling to the left past two round tables with residents seated in their wheelchairs; then, while in a forward motion, bumped into the oxygen tank of resident #26 and the back of the w/c of sleeping resident (#12). During the forty-five minutes of the observation, there were

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 780 N 780 Continued From page 24 no staff members in the dining room. Observation of the Wing I dining room on October 18, 2011, from 11:55 a.m., until 12:35 p.m., revealed resident #15 with the back of w/c up against the dining room wall to the left of the double door. Observation at 12:20 p.m., revealed resident #15 peddled in a forward motion about eight feet and rammed into one of the dining tables where resident #14 was eating. Observation continued and the ramming motion was repeated three more times, then resident #15 retreated about four feet, paused for four minutes, and then rammed into the same dining table again. Observation then revealed certified nursing assistant (CNA #12) came to the table of resident #14 and took resident #15 back to the former spot. 1 Interview with the Assistant Director of Nurses (ADON) on October 19, 2011, at 10:00 a.m., verified the resident had interactions with other residents filed in formal reports and confirmed the resident did not have the unsafe use of the wheelchair care planned. During interview, the ADON stated social services were responsible to assess behaviors and verified the resident's unsafe behavior with the w/c affecting other residents was not appropriately assessed on the October 2011 MDS and had not been care planned to develop interventions for the behavior. Interview with the Nurse Practitioner (Psych Mental Health Nurse Practitioner/PMHNP) contracted for psychiatric consults on October 21. 2011, at 9:10 a.m., in the DON's office revealed the social services staff had not formally requested a consult related to the resident and stated the primary responsibility for addressing behaviors was with the facility's Licensed Clincal

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING TN0601 10/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 780 N 780 Continued From page 25 Social Worker (LCSW). Interview in the conference room with the LCSW at 11:15 a.m., on October 20, 2011, revealed the LCSW stated, "assisstant responsible for that resident (referrring to resident #15). Interview verified the LCSW had not been consulted related to the resident's behaviors with the w/c. Interview continued, the social services assistant joined the interview and verified after assessing the resident with behaviors in October 2011, the social services staff did not work in conjunction with the Interdisciplinary Team to develop interventions in an effort to maintain the safety of the resident and the other residents on Wing I & IV (resident #15 had been documented wandering onto Wing IV frequently). Resident #27 was admitted to the facility on October 15, 2011, with diagnoses of Schizophrenia, Anxiety, Depression, and Vascular Dementia with Delusions. Medical record review of the resident assessment dated September 27, 2011, revealed the resident was cognitively intact and had no mood or behavior indicators. Medical record review of the Nurse's Notes dated October 9, 2011, revealed, "...Res (resident #27) was in...room et (and) res (#15)...came in and... (resident #27) yelled...to get out then took...water pitcher et threw water in...(resident #15) face...left message for Social Services..." Medical record review of the Social Service Progress Notes revealed the last entry was dated September 27, 2011.

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 780 Continued From page 26 Interview with the Social Worker Assistant on October 24, 2011, at 8:15 a.m., on Wing One Nurses' Station, confirmed Social Services had not completed a follow up for the resident's behavior on October 9, 2011. Medical record review of the Psychiatric Note dated September 29, 2011, revealed, "...complex behaviors...fixed delusions...nursing staff to monitor resident's behaviors..." Medical record review of the Psychiatric Note dated October 14, 2011, revealed, "...risperdal (antipsychotic)...depakote (medication for Schizophrenia) for behaviors...continues to have fixed delusions...nursing staff to monitor behaviors..." Medical record review of the Interdisciplinary Plan of Care dated March 8, 2011, revealed the care plan had not been revised to reflect the resident's behaviors. Resident #30 was admitted to the facility on November 26, 2008, with diagnoses including Alzheimer's Dementia with Behaviors, Impulse Control and Parkinson's Disease. Medical record review of the resident assessment dated October 4, 2011, revealed the resident was moderately impaired for decision making and behaviors occurred four to six days a week. . . Medical record review of the facility documentation dated June 27, 2011, revealed, "...residents(#12 and #30) verbally arguing... (resident #30) slapped resident (#12) across face..."

Medical record review of the facility

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 780 N 780 Continued From page 27 documentation dated October 15, 2011, revealed, "...heard altercation...resident started hitting resident on right lower jaw..." Medical record review of the Nurse's Notes dated October 15, 2011, revealed, "...resident got into an altercation...separated residents...placed in N.P. (Nurse Practitioner) book..." Medical record review of the Interdisciplinary Plan of Care dated October 7, 2011, revealed the care plan had not been revised to reflect the resident's behaviors. Medical record review of the resident's chart revealed no social service notes, nurse practitioner notes, or behavior monitor form addressing behaviors, and the facility had not referred the resident for psychiatric examination. Interview with the Wing One Clinical Manager (CM), on October 20, 2011, at 10:00 a.m., in the Wing One Nurses' Station, confirmed the resident had a history of altercations with other residents, the facility had not addressed the residents behaviors in the care plan, and had not put a behavior management plan in place. Interview with the Director of Nurses on October 24, 2011, at 8:10 a.m., in the DON's office verified the social service assistants did not have the training and expertise of the LCSW. During the interview, the DON confirmed the social services department had not developed interventions and did not have a behavior management program in place to to address the resident #12's intrusive behaviors, resident #15's unsafe behaviors with the wheelchair, and residents #27 & #30's aggressive behaviors towards other residents.

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1200-8-611(2)(a)	1. Records and Reports		N1102			
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Based on medica investigation reviet the facility failed to report to the State origin for one (#1 reviewed. The fainvestigate and reinjury of unknown enviroment detrin safety and welfar.  The findings included the state of the findings included the state of the st	I record review, facility ew, policy review, and in to thoroughly investigate e Agency, an injury of ur 2) of forty-nine residents icility's failure to thorough eport to the State Agency origin placed resident anental to the resident's hee.  Juded:  s admitted to the facility to the admitted to the facility one, with diagnoses included the placed resident's hee.	and aknown  nly  y, an  12 in an ealth  on uding: sease,		was substantiated per clinical assessment. The medical director was notified by DON on October 2011. NP was notified by DON October 28, 2011. Medical direct & NP were notified of investigation on 11/8/11 by DON.	or r 25, on ctor ion No	
	CORRECTION  DVIDER OR SUPPLIER  HEALTH CARE & RE  SUMMARY (EACH DEFICIE REGULATORY)  1200-8-611(2)(a)  (2) Unusual event facility to the Depa designed by the D business days of the abuse of a pat occurrence of acc threatening or set  (a) The following could result in an unexpected occur death, life threate patient, not relate patient, not relate patient's illness or circumstances that event include, but  1. medication err  This Rule is not r Based on medica investigation revie the facility failed t report to the State origin for one (#1 reviewed. The fa investigate and re injury of unknown enviroment detrin safety and welfar  The findings inclu Resident #12 wa December 11, 20 Dementia with Be	TN0601  DVIDER OR SUPPLIER  HEALTH CARE & REHAB  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF LSC IDENTIFY I	TN0601  STREET AT 2910 PET CLEVELJ  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1200-8-611(2)(a)1. Records and Reports  (2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient.  (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:  1. medication errors;  This Rule is not met as evidenced by: Based on medical record review, facility investigation review, policy review, and interview the facility failed to thoroughly investigate and report to the State Agency, an injury of unknown origin for one (#12) of forty-nine residents reviewed. The facility's failure to thoroughly investigate and report to the State Agency, an injury of unknown origin placed resident #12 in an enviroment detrimental to the resident's health safety and welfare.	DONDER OR SUPPLIER  HEALTH CARE & REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1200-8-611(2)(a)1. Records and Reports  1200-8-611(2)(a)1. Records and Repo	TN0601  STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PERKLESS RD CLEVELAND, TN 37312  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEMIFFING INFORMATION)  1200-8-611(2)(a)1. Records and Reports  (2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department of Health in a format designed by the Department of Health in a format designed by the results in death, life threatening or serious injury to a patient.  (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's lines or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:  1. medication errors;  This Rule is not met as evidenced by: Based on medical record review, facility investigation review, policy review, and interview the facility failed to thoroughly investigate and report to the State Agency, an injury of unknown origin for one (#12) of forty-nine residents reviewed. The facility's failure to thoroughly investigate and report to the State Agency, an injury of unknown origin placed resident #12 in an environment detrimental to the residents's health safety and welfare.  The findings included:  Resident #12 was admitted to the facility on December 11, 2008, with diagnoses including: Dementia with Behaviors, Alzheimer's Disease,	

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD **BRADLEY HEALTH CARE & REHAB** CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1102 N1102 Continued From page 29 vacation or leave and they will be inserviced on date of return to work. dated September 6, 2011, revealed the resident All agency staff will be in-serviced had severe cognitive impairment and equired prior to work. Revised abuse policy extensive staff assistance for transfers, mobility, on November 6, 2011 was combining and some activities of daily living. unknown injuries/accident incidents Medical record review of a nurse's note dated to be included in policy. No new July 22, 2011, by Licensed Practical Nurse (LPN) information was added. State was #6 revealed, "10:40 p.m. My aide came to me notified of incident & investigation and told me Certified Nursing Assistant (CNA) #8 through IRS system on 11/7/11. found a bruise...I went to look at it...bruise to L B. All residents with incidents of (left) leg to the inside." unknown origin have the potential to be affected by this deficient process. Review of the facility investigation and a signed Incident reports from July 22, 2011 to statement by CNA #8, dated July 22, 2011, current were reviewed by ADON on revealed. "I can see on resident's (res) face (res) 11/7/11 and review of 44 unknown in pain...I saw a huge bruise on left leg inside...I incidents required no further action. notice before the bruise near the pelvic area is swollen, so I reported to my charge nurse (LPN Incidents of unknown origin are #6)." Continued review of facility investigation being reviewed by nursing and a signed statement by LPN #6 dated July 22, management initially (daily as 2011, revealed, "My aide (CNA #8) came and told occurrence) and ADON (QA nurse) me the resident had a bruise on (res) leg at 10:30 receives incident, and the p.m., Friday, 7-22-11. I went and pt (patient) was investigation begins immediately, the in bed on R (right) side and aide pulled pt leg abuse coordinator and administrator apart and I saw a bruise on L (left) leg to inside immediately receive copy of incident and red in color." as notification to begin investigation. MD/NP will be notified of each Review of the Weekly Skin Assessment form incident as well as contact person dated July 22, 2011, revealed a body diagram (family). Medical director will be with the right leg shaded in, from the knee to the notified of any injury, during the pelvis. The diagram was labeled "lg (large) bruise investigation process. All agencies with edema." (DHS, state & local agencies, and law Medical record review of a nurse's note dated enforcement) will be notified of abuse July 23, 2011, revealed, "CNA called nurse to res allegations, as per facility policy. In-(resident) room after assisting res to bed. This servicing of all staff will be done nurse noted purple bruising and swelling from the quarterly as scheduled and as an inner R (right) thigh extending down to the calf. incident occurs, in-servicing will be Also, redness warmth and swelling to the R (upper) thigh...resident will holler out and grab leg

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N1102	with range of motion (named physician): diagnostic test) in a. DVT (Deep Vein Thr (Medical Doctor) of rorder"  Review of facility invistatement by CNA # 9:15 p.m., revealed, ready for bed notice leg, went and got nu Continued review of July 23, 2011, reveal "bruising & (and) sextending down to Review of the facility Healthcare & Rehability Healthcare & Rehability Healthcare & Rehability injuries/Accidents of 4-21-08) revealed, "means to monitor in part of an on-going of an assessment of the discovered the Director of Nursimmediately when the where suspicion of allegations of abuse Administrator/Director responsible to notify	venous Doppler (ultras m. to R leg to R/O (rule rombosis). Notify MD results for possible X-rarestigation and a signed estigation and a signed state of the results for possible X-rarestigation and a signed state of the results for possible X-rarestigation and a signed state of the results for possible X-rarestigation and a signed state of the facility documentation of the facility will provide puries of unknown Origin (revisity of the facility will provide puries of unknown origin quality assurance programs the facility to identify the facility to identify the resident's conditions of the injury by other rest6. The Administrate ing must be notified there are injuries presentabuse or neglect, or	ound out)  y  I, at	N1102	c si ni ii a a w w d d b a a ni d d c c r r r r r r r r r r r r r r r r	one by nursing managem oordinator and/or departnupervisor. Nurses, nursing management, QA nurse was needed in the control of the partment supervisors and abuse control of the partment supervisors and seen in-serviced on abuse buse coordinator & nursing nanagement completed 1 department supervisors with the partment supervisors with the partment supervisors with the partment supervisors with the partment supervisors with the partments along with a coordinator and administrational of the partments along with a coordinator and administrational of the partment of the partments of the partments of the partments along with a coordinator and administrational of the partment of the par	nent  g ill  ughly. The  coordinator dent report der d staff have policy by ng 1/7/11 and ll ving their use ator. Abuse abuse of ext Resident nown nation of injuries buse, or d per abuse each n Nurses & egin the upon sed on coordinator ncident and tion, other nies, & local	

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N1102	Review of the facility document by the Ass (ADON) dated July 2 continues @ (at) this prior shift/rounds. Re with bed mobility and review revealed no or interventions had Interview with CNA # 21, 2011, at 11:10 a. discovered bruising a "left thigh and pelvic bruising and swelling in the shift and was c CNA #8 stated the bruising the charge nurse (LPN # #8 clarified the "pelvidentify the specific a "swelling."  Interview with LPN # 21, 2011, at 1:15 p.n kinda remember a bipinkish-purple kind to seeleft the resid nurses' station to collinterview with Treatment and skin on urses), on October conference room, reroutinely did treatment together, frequently the hours of 7:00 p.I. Nurse #2 stated, "I'r documenting the brus of the see	istant Director of Nursi 6, 2011, revealed, "Bru time. Bruising not note sident requires assista I transfers." Continued ther examination, follow been implemented.  8, by telephone, on O m., confirmed CNA #8 and swelling to resident area." CNA #8 stated ghad not been noticed causing the resident pa ruising was reported to 60 when discovered. O ic area" as "vaginal are anatomical location of the fanot hugekinda diff tent's room and returne mplete incident report."  ment Nurse #2, one of care nurses (licensed p 21, 2011, at 8:45 a.m. evealed the treatment n ents and skin assessme on the evening shift, di m. to midnight. Treatm emember looking at ar uising (on resident #12) w revealed Treatment	ng dising do on nce  w-up, ctober t #12's the earlier in. the CNA tan'to he ttober ated, "I ficult do to  two ractical , in the urses ents uring ient hd o on	N1102		facility policy. Incident rep be trended in QA monthly a unknown, conclusion, & ty injury and intervention. Tr results will be a QA audit v interventions taken to decre common incidents. Membe committee are: Administra medical director, DON, AE clinical managers, pharmac consultant, activities direct representative, treatment no restorative nurse, social ser director or representative a other staff requested to atte situation dictates based on findings. Each incident of unknown behavior issues will be rev daily upon occurrence. Al- incidents of unknown origi behavior issues, restraint application/elimination and application/elimination will reviewed weekly at sub QA The administrator attends a sub QA meetings unless or facility and receives report appropriate. Education & staff regarding abuse, unkn incidents, Behavior Manag Plans will be ongoing. Ad will continue to be involve services. Incidents will be reviewed discussed in the weekly m	as to pe of ending with ease ers of QA utor, DON, ey or or urse, rvice nd any end as QA origin & iewed so in, d alarm II be A meetings. all weekly utside es as training of nown origin gement lministrator ed in in-		

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 10/24/2011 TN0601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1102 N1102 | Continued From page 32 nursing admin., rehab department Review of Treatment Nurse #2's time card, rep., pharmacy consultant, medical provided by the facility's Pay Roll Clerk, revealed director, administrator, and any other Treatment Nurse #2 had not clocked in after 2:06 p.m. on July 22, 2011, (The bruises and swelling appropriate staff according to nature were discovered and reported at 10:30 p.m. by of incident. CNA #8, eight hours and twenty-four minutes Administrator will read and review after Treatment Nurse #2 had clocked out for the all reports concerning potential day). abuse/injuries of unknown origin along with the incident report and Review of the Weekly Skin Assessment dated also interview personnel having any July 22, 2011, revealed the skin assessment for direct knowledge of the incident to resident #12 had been initialed and completed by ensure that incident does not reoccur Treatment Nurse #1 on July 22, 2011. and this information will be included in the QA meeting for review and Interview with Treatment Nurse #1, on October follow up. 21, 2011 at 8:58 a.m., in the conference room, revealed, "I don't remember...if that's what I wrote, I guess that's right. I don't remember specifics..." Interview with Nurse Practitioner #1 (NP) by telephone, on October 20, 2011, at 5:48 p.m., revealed NP #1 had not been made aware of the extent of the bruising to the resident. During interview, NP #1 stated, "...had I known the bruising was that large and/or involved the pelvic area then I would have examined the resident personally, as well as insisted on a complete investigation to determine the cause of the injuries and to rule out any inappropriate contact." Interview with the Medical Director, by telephone, on October 21, 2011, at 2:25 p.m., revealed the Medical Director was not aware of resident #12's bruises discovered on July 22, 2011, and July 23, 2011. The Medical Director stated, " no I was not aware of this ... and the facility needed to find out exactly what happened...due to the obvious implication of possible sexual

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0601			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  10/24/2011		
	**************************************	1140001	STREET ADDRE	ESS, CITY, STATI	E. ZIP CODE		
BRADLEY HEALTH CARE & REHAB  STREET ADDRESS, CITY, STATE, 2F GOOD  2910 PEERLESS RD  CLEVELAND, TN 37312							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N1102	on October 20, 2011 bruising of unknown the resident and no completed to been determined. The follow-up examination been completed, nor identified to prevent reoccurring. The ADC bruising had not been an injury of unknown	DON, in the conference, at 12:20 p.m., confirmorigin had been identification and the ADON confirmed non or documentation had had any intervention bethis type of injury from ON further confirmed the investigated or reported origin, and the facility's	ed ed on ad d een ee as	N1102			
	policy related to "Res Unknown Origin" had Interview with the Nu (NHA), on October 2 conference room, re necessarily advised review all incident re with serious injuries The Administrator co been thoroughly investigated bruises had never be Administrator further related to injuries of	sident Injuries/ Accident d not been implemented ursing Home Administra t1, 2011, at 8:12 a.m., in	ts of d.  ttor n the don't ved  not for the policy t been				